STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155636	A. BUILDING _____ B. WING _____	C 02/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARRISON TERRACE	1924 WELLESLEY BLVD INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00123752 and IN00123794. This visit was in conjunction with a Post Survey Revisit (P.S.R.) to the Investigation of Complaint IN00121723 completed 1/15/13. Complaints IN00123752 and IN00123794 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: February 25, 26, 27, 28, 2013 Facility number 000241 Provider number 155636 AIM number 100291310 Survey team: Chuck Stevenson RN Census bed type: SNF/NF: 106 Total: 106 Census payor type: Medicare: 13 Medicaid: 73 Other: 20 Total: 106 Sample: 5 Harrison Terrace was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to the Investigation of Complaints IN00123752 and IN00123794.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 Quality review 3/04/13 by Suzanne Williams, RN	F 000		